Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pine Creek Medical Center

Respondent Name
Indemnity Insurance Co of North

MFDR Tracking Number
M4-14-1532-01

Carrier's Austin Representative Box
Box Number 15

MFDR Date Received
January 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…our facility was under paid per DRG 460 & Implants."

Amount in Dispute: $ 6,745.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier re-reviewed the bill upon receipt of the request for reconsideration and determined there was still an overpayment and no further benefits were due."

Response Submitted by: Smith & Carr, P.C. 9235 Katy Freeway, Suite 200, Houston, TX 77024

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2012	Inpatient Hospital Services	$6,745.45	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W5 – Request of recoupment for an overpayment made to a health care provider.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
   - W1 – Workers Compensation State Fee Schedule adjustment.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's

MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute is July 26, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on January 28, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services found the following:

a. Refund notice processed by Sedgwick on 8/15/2013.
b. 28 Texas Administrative Code 133.307(c)(1)(B)(iii) states, "the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice."
c. Medical Fee dispute filed January 28, 2014, outside of 60 days as required by guideline.

The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 1, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.